DEPARTMENT POLICY

All Programs

Clients must complete and sign one of the following application forms:

- MDHHS-1171, Assistance Application, and program specific supplement form(s):
    - MDHHS-1171-CASH, Supplement-Cash Assistance.
    - MDHHS-1171-CDC, Supplement-Child Development and Care.
    - MDHHS-1171-HCC, Supplement-Health Care Coverage.
    - MDHHS-1171-FAP, Supplement-Food Assistance Program.

  Note: A MI Bridges online application is considered the same as the MDHHS-1171 and program specific supplement form(s) or a DCH-1426.
- DHS-4574, Medicaid Application (patient of nursing facility).
- DHS-4574-B, Assets Declaration (for initial asset assessment); see Bridges Eligibility Manual (BEM) 402.
- DCH-1426, Application for Health Coverage & Help Paying Costs.

Any application or the MDHHS-1171, Filing Form, with the minimum information, must be registered in Bridges; see BAM 110, Response to Applications.

Following registration of the application, do **all** of the following:

- Interview clients when required by policy; see INTERVIEWS in this item.
- Certify eligibility results for each program within the applicable standard of promptness (SOP); see Standards of Promptness and Processing Delays in this item.

- Bridges automatically generates a client notice informing them of the eligibility decision. Bridges Administrative Manual (BAM) 220 explains the use of client notices.

Helping Clients

All Programs

The local office must assist clients who need and request help to complete the application form.

The time limit to respond to requests for help completing the application form depends on the circumstance:

- For clients in the local office, respond within one workday.
- For clients who send a letter, respond by a return letter or phone call within five workdays.
- For clients who telephone, respond by either of the following:
  - Return phone call within one workday**.**
  - Send letter within five workdays.

When help **cannot** be provided by phone call or letter within specified time frames, complete a home call within five workdays.

The local office must have designated staff to make home calls to help complete applications in all of the following:

- Sufficient help **cannot** be provided by telephone or letter.
- The client is physically unable to come to the office.
- The client has no one else to help or to come to the office on his/her behalf.

Signature Requirement

All Programs

Before the application or MDHHS-1171, Filing Form, is registered, it must be signed by the client or authorized representative (AR).

Note: The signature(s) establishes both of the following:

- Client and/or AR understand their rights and responsibilities.
- Client and/or AR prepared the application or filing form truthfully under penalty of perjury.

Medicaid

A MDHHS-1171, Filing Form, is not used to register a request for assistance.

CDC Only

An applicant who is unable to write may sign with an **X**, witnessed by one other person such as a relative, friend, department specialist, etc.

If the MDHHS-1171 is updated by the client to request CDC, it must be re-signed and dated.

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance (RCA) and Food Assistance Program (FAP) Only

If an in-person interview is held, the client and/or AR must sign and date the application in the specialist's presence, **even if** it was already signed. Sign and date the application as a witness.

FAP Only

If the FAP group does **not** have an adult **or** an AR, a minor group member must sign the application.

FIP Only

If an in-person interview is held (**all** adult mandatory group members in the home must sign the application in the presence of the specialist if physically able.

If a telephone interview is an option for the group the specialist must do all of the following:

- Send the DHS-1173, Cash Assistance Rights and Responsibilities, to **all** adult mandatory group members in the home that have **not** signed the MDHHS-1171. Do **not** approve eligibility until the DHS-1173 is signed **and** returned by **all** other adult mandatory group members.

  Note: If the application is a MI Bridges online application, the head of household has electronically signed the MDHHS-1171. All other adult mandatory group members in the home have **not** signed the MDHHS-1171.

- Send the DHS-1538, Work and Self-Sufficiency Rules, to **all** adult mandatory group members in the home. Do **not** approve eligibility until the DHS-1538 is signed **and** returned by **all** adult mandatory group members.

  Note: If the application is a MI Bridges online application, the head of household has electronically signed the DHS-1538. Do not send the head of household on a MI Bridges application a new DHS-1538 unless requested. **All** other adult mandatory group members in the home have **not** signed the DHS-1538.

- If a MDHHS-1171, DHS-1173 or DHS-1538 is returned to the MDHHS office with a signature that is questionable, require the client to re-sign the MDHHS-1171, DHS-1173 or DHS-1538 in the local office and witness the signature on the required form.

SDA and RCA Only

The client's **spouse and other adult mandatory group members** in the home must sign the application in the presence of a specialist if physically able.

SDA Only: If the SDA application is a MI Bridges online application, the head of household has electronically signed the application. Other adult mandatory group members have **not** signed the application. Require **all** other adult mandatory group members in the home to sign the DHS-1173 in the specialist's presence if physically able. Do **not** approve eligibility until the DHS-1173 is signed by **all** other adult mandatory group members.

RCA Only: If the RCA application is a MI Bridges online application, the head of household has electronically signed the application and the DHS-1538. Other adult mandatory group members have **not** signed the application and the DHS-1538. Require **all** other adult mandatory group members in the home to sign the DHS-1173 and the DHS-1538. Do **not** approve eligibility until the DHS-1173 and the DHS-1538 are signed by **all** other adult mandatory group members.

Member Add Signature Requirements

FIP Only

All adult mandatory group member adds must sign and return the DHS-1173 and DHS-1538. Do not approve eligibility of the member

add until the DHS-1173 **and** DHS-1538 is signed and returned for **each** adult mandatory group member add.

INCOMPLETE APPLICATIONS

All Programs

An incomplete application contains the minimum information required for registering an application. However, it does not contain enough information to determine eligibility because all required questions are not answered for the program(s) for which the client is applying; see BAM 105.

When an incomplete application is filed, retain the application and give or send the client the DHS-3503, Verification Checklist. Inform the client of the:

- Request for contact to complete missing information.
- Due date for missing information**.**
- Interview date, if applicable.

If an interview is necessary, conduct it on the day of the filing, if possible. Otherwise, schedule it for **no later than 10 calendar days** from the application date.

If a client submits a MDHHS-1171, Assistance Application, but does not submit the program specific supplement form(s), treat this as an incomplete application.

Exception: Accept program specific applications in place of the program specific supplement form(s).

Application Completed Later

All Programs

When incomplete applications become complete, explain the situation in the case notes section of the application form or in case comments in Bridges.

Example: Incomplete application filed October 3, 2016; became complete October 17, 2016.

When the applicant or the representative completes a previously incomplete application, the application must be re-signed and re-dated on the signature page.

Bridges retains the original registration date, regardless of how or when the application becomes complete.

Failure to Complete the Application Process

All Programs

Do **not** deny an incomplete application until 10 calendar days from the **later** of either the initial:

- Request in writing to the applicant to complete the application form or supply missing information.
- Scheduled interview.

Exception: For FAP, do **not** deny an application if the client has not participated in the **initial interview** until the **30th** day after the application date **even** if they have returned all required verifications. When denying cases on the 30th day, navigate to the *Program Request Details* screen and select *Failed to Attend Food Assistance Intake Interview* as the reason for the denial. The initial interview **must** be scheduled as an in-person appointment, phone appointment or home call.

APPLICATION AFTER DENIAL/ TERMINATION

All Programs

The following applies when an application is denied **or** eligibility is terminated before the month of a scheduled redetermination or end date:

- The application on file remains valid through the last day of the month **after** the month of the denial or termination. To reapply during this time, the client/AR must do all of the following:
  - Update the information on the existing application.

- Initial and date each page next to the page number to show that it was reviewed.
- Re-sign and re-date the application on the signature page. This becomes the new application date.
- Comply with all application requirements.

- If eligibility exists, the updated application is valid until the redetermination or end date.

Reminder: An application *cannot* be updated or re-signed outside the local office except as part of a home call.

REINSTATEMENT

All Programs

A new application is **not** required to reinstate eligibility; see BAM 205, Reinstatements.

WHEN TO USE THE MDHHS-1171

All Programs

The MDHHS-1171 and program specific supplement form(s) must be completed:

- When applying for program benefits.
- When case management dictates.

Exception: Medicaid (MA) categories use separate application forms; see *when to use the* DHS-4574 in this item.

At Initial Application

All Programs

A **separate application** is required for **each group**.

Exception: Only one application form is required when MA groups, even with separate case numbers, live together such as spouses applying for different MA categories. An application may be photocopied or cross referenced for multiple case files.

An application form is generally valid for 12 months from the date eligibility is initially certified in Bridges.

Exception: For FAP, the period might be fewer or more than 12 months; see Benefit Periods under *eligibility decisions* in this item.

MA Only

A separate application is required for anyone **not** in the home, such as one spouse at home and the other in long term care (LTC).

FAP Only

A FAP group might be ineligible in the month of application but eligible for a future month due to changes in circumstance:

- Use the same MDHHS-1171 and MDHHS-1171-FAP, to deny eligibility for the application month and to determine eligibility for later months.
- It is not necessary to interview the FAP group again, **but** Bridges will request any additional needed verification.
- Do **not** deny and re-register the application in Bridges. Certifying approval for the next month disposes of the registration.

At Program Transfer

All Programs

When recipients request benefits they are **not** currently receiving, use the MDHHS-1171 or DCH-1426 on file **if** it was approved within the last 12 months.

- Update the application and data collection to add or change information to transfer among MA only categories. The client does not have to re-sign the application.
- For other transfers, update the application **and** have it re-signed; see WHEN THE MDHHS-1171 IS NOT NEEDED in this item. Register the new program using the date the application form was re-signed as the application date.

Eligibility for a new program or MA category is limited to the renewal or end date already in Bridges.

Exception: When an ex parte review of a client's current Medicaid eligibility case file shows the recipient indicated or demonstrated a disability (see glossary), continue Medicaid until information needed to proceed with a disability determination has been requested and reviewed. Continue Medicaid coverage until the review of possible eligibility under other Medicaid categories has been completed; see BAM 210 and BAM 220.

MA Only

A recipient losing Medicaid under a category for which a DCH-1426 is not needed may need to complete a DCH-1426 in order to transfer to another MA category if a DCH- 1426 has not been approved for another program within the past 12 months. Always give the recipient a reasonable opportunity to complete the DCH-1426 and to provide the verification of eligibility under other categories **before** termination of MA; see BAM 220, Case Actions.

Exception: Transitional MA eligibility is 12 months from the date of Low-Income Family (LIF) ineligibility; see BEM 111, Transitional MA.

At Redetermination/ Renewal

FIP, SDA, CDC, SSI-Related MA and FAP Only

A new application, MI Bridges redetermination or MDHHS-1010, Redetermination and program specific supplement form(s), must be completed at each redetermination of eligibility.

Exception: When policy requires a benefit period shorter than 12 months, the MDHHS-1171 and specific program supplement form(s), DCH-1426 or MDHHS-1010 and program specific supplement form(s) on file may be updated and re-signed if **both** of the following apply:

- The application/redetermination was initially certified within the last 12 months.
- The client is interviewed (if required) and provides any needed verification before redetermination.

MAGI Medicaid

MDHHS must use information currently available in State of Michigan systems to renew eligibility. Do not request information from the beneficiary if the information is already available to MDHHS. This includes completing a renewal form. See BAM 210, Redetermination/Ex parte review/Renewal.

FIP

At redetermination, if an adult mandatory group member is added to the group, send the individual the DHS-1173 **and** DHS-1538. Do **not** approve the redetermination until the DHS-1173 **and** DHS-1538 are signed **and** returned. See additional requirements in BAM 210, Member Add at Redetermination.

WHEN A DCH-1426 IS NOT REQUIRED

MA Only

No DCH-1426 is required to apply or renew Medicaid or in the following instances:

- Transfers to:
  - Transitional MA; see BEM 111.
  - Special N Support; see BEM 113.
  - Refugee Medical Aid; see BEM 630, REFUGEE ASSISTANCE PROGRAMS.
- Transfers between Medicaid categories; see At Program Transfer, in this item.
- Supplemental Security Income (SSI) recipients.
- **Automatically** eligible newborns; see BEM 145, Newborns. Authorize the newborn's MA as soon as the child's birth is reported. Contact the newborn's mother if there is **not** enough information to obtain a beneficiary ID for the child in Bridges.
- Beneficiaries who complete the DHS-4574, Patient of Nursing Facility.
- Department wards, Title IV-E recipients and special needs adoption assistance recipients; see BEM 117, DEPARTMENT WARDS, TITLE IV-E AND ADOPTION RECIPIENT.

- Individuals who apply through the Federally Facilitated Marketplace (FFM).

WHEN TO USE A DHS-4574

MA Only

Instead of the DCH-1426, the DHS-4574, Medicaid Application (Patient of Nursing Facility), for LTC beneficiaries (do not use for waiver beneficiaries) may be used.

An approved application is current for 12 months from the original disposition date.

RETRO MA APPLICATIONS

MA Only

Retro MA coverage is available back to the first day of the third calendar month prior to:

- The current application for FIP and MA applicants and persons applying to be added to the group.
- The most recent application (**not** renewal) for FIP and MA recipients.
- For SSI, entitlement to SSI.
- For department wards; see BEM 117, DEPARTMENT WARDS, TITLE IV-E AND ADOPTION RECIPIENT, the date MDHHS received the court order for a department ward.
- For Title IV-E and special needs adoption assistance recipients; see BEM 117, DEPARTMENT WARDS, TITLE IV-E AND ADOPTION RECIPIENT, entitlement to title IV-E or special needs adoption assistance.

Exception: Full-coverage QMB eligibility **cannot** be retroactive. ALMB **cannot** be authorized for a previous calendar year; see BEM 165.

Exception: A person might be eligible for one, two or all three retro months, **even if not** currently eligible. The DHS-3243, Retroactive Medicaid Application, is used to apply for retro MA.

Only one DHS-3243 is needed to apply for one, two or all three retro MA months; see RETRO MA APPLICATIONS in BAM 110.

Do not request a DHS-3243 if the individual is eligible under Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) Retro MA Eligibility Requirements.

Eligibility must be made for **each** of the three retro months; see BAM 115 Standard retro MA eligibility requirements.

When the need for retroactive coverage, including specific months, is indicated on the DCH-1426, DHHS 1171, Healthcare coverage supplement, or MI Bridges, a separate DHS-3243 is not required.

Children Under 19 (U19), Pregnant Women (PW), MIChild (MCD)

Determine eligibility for the application month first. An individual who is eligible for Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) for the application month is eligible for retro MA when all of the following conditions are met.

This applies **even if** the retro MA question on the application is not answered or is answered no.

1. The client is eligible for Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) for the application month.

2. For a pregnant woman, the woman was pregnant or under age 19 for the retro MA month.

3. The person was a Michigan resident. Retro MA **cannot** be approved for a month if you know the person was **not** a Michigan resident for the retro MA month. However, assume a person was a Michigan resident unless you have information to the contrary, such as information on the application indicating the person lived in another state.

4. The person is **not** ineligible because of BEM 265, INSTITUTIONAL STATUS. Retro MA **cannot** be approved for a retro MA month if you know the person would be ineligible because of institutional status. However, assume a person was **not** institutionalized unless you have information to the contrary.

5. Any applicable post-eligibility patient-pay amount has been computed. An application month may be a long term care

and/or hospital (L/H) month or you may have information suggesting that a retro MA month is an L/H month. In such situations, decide whether a retro MA month is an L/H month and compute the post-eligibility patient-pay amount. Do **not** approve retro MA coverage for a month until that decision and/or computation is completed.

6. Use the Standard Retro MA Eligibility Requirements below to determine retro MA eligibility if the client is **not** eligible for Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) for the application month.

Parent/Caretaker (PCR), Healthy Michigan Plan (HMP), Former Foster Care (FFC)

MAGI groups which were automatically approved and certified using federal trusted data sources meet the requirements for retroactive Medicaid with no additional verification.

- Individuals must request and be approved for only the specific months they need coverage for, not automatic coverage as is true for U19, PW, and MIChild.
- Must meet programmatic requirements for requested months.
    - PCR-must have a dependent child during the requested month(s).
    - HMP- retro month must be April 2014 or later. Not a Medicare recipient, at least age 19 and under 65.
    - FFC- not in foster care during retro months.

Standard Retro MA Eligibility Requirements

MA Only

Determine eligibility for **each** retro MA month **separately**.

To be eligible for a retro MA month, the person must:

- Meet all financial and nonfinancial eligibility factors in that month, and
- Have an unpaid medical expense incurred during the month, or

Note: Do **not** consider bills that the person thinks may be paid by insurance as paid bills. It is easier to determine eligibility sooner rather than later.

- Have been entitled to Medicare Part A.

Reminder: There is **no** asset test for MAGI-related Medicaid categories.

Financial eligibility policies might affect a pregnant woman's eligibility for retro months.

When a client is eligible for a retro month that is **also** an L/H month, determine the post-eligibility patient-pay amount; see BEM 546.

UPDATING THE APPLICATION

All Programs

An application is **never** returned to the client or AR to update.

While an application is considered valid, the client may update the current application rather than complete a new one to add or transfer programs or add a member.

Note: To add a new program, the corresponding program specific supplement form(s) or DCH-1426 for healthcare coverage, must also be completed by the client or documented by the specialist.

Allow updating only if it can be done without obliterating the previous information and there is sufficient room to legibly add the new information. The client must sign and date the application again after updating it.

Exception: For **FIP** dependent child member adds, obtain the information necessary to add the member and document the case record. The client is not required to sign and date the updated application.

Exception: For CDC child or adult member adds, obtain the information necessary to add the member and document the case record. The client is not required to update the application; see BAM 220 for CDC MEMBER ADDS.

Note: For **FAP**, an interview and an updated application can be requested but **cannot** be required to add a member.

Example: Alexis is scheduled for an interview to add her boyfriend to her FAP case. She supplies all requested verifications needed to determine eligibility but fails to attend the interview. Process the member add. Do **not** deny the member add or close the case.

STANDARDS OF PROMPTNESS

All Programs

The SOP begins the date the department receives an application/filing form, with minimum required information.

Exception #1: For **FAP**, the SOP begins when the **correct** local office receives it; see BAM 110, WHERE TO APPLY/PROCESS APPLICATIONS, FAP ONLY.

Exception #2*:* For **FAP**, when a person applies for SSI and FAP before being released from a medical institution, the SOP begins on the applicant's date of release.

See BAM 105, for the minimum required information for filing.

Process applications and requests for member adds as quickly as possible, with priority to the earliest application date; see Processing Delays in this item. Requests for member adds must be entered in Bridges.

FIP Only

Upon immediate receipt of the FIP application, the specialist must run the FIP Eligibility Determination Group (EDG) in Bridges to timely generate an automated Partnership. Accountability. Training. Hope. (PATH) referral, as well as the DHS-4785, PATH Appointment Notice, to the client. While the specialist should run the FIP EDG immediately, this must be completed within five days of the application date. Certify FIP program approval or denial of the application within 45 days.

Note: The specialist must review the MDHHS-1171 and MDHHS-1171-CASH, for any potential deferral requests prior to running the FIP EDG; see BEM 230A.

SDA, RCA, RMA and MA Only

Certify program approval or denial of the application within 45 days. Bridges automatically generates the client notice.

Exceptions:

- 15 days for all pregnant Medicaid applicants.
- 30 days for Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) applicants.
- 60 days for SDA applicants.
- 90 days for MA categories in which disability is an eligibility factor.

  The SOP can be extended 60 days from the date of deferral by the Medical Review Team.

CDC Only

Certify program approval or denial within 30 calendar days from the receipt of application. Bridges automatically generates the client notice.

Exception: For groups entitled to CDC expedited service, CDC eligibility must be determined by the seventh calendar day following the date of application; see BAM 118 CDC Expedited Service.

MA Only

The SOP for an **initial asset assessment** begins the date the local office receives a signed DHS-4574-B, Assets Declaration. Complete the assessment and mail the client and spouse a notice within 45 days; see BEM 402.

FAP Only

The expedited due date (SOP) is six calendar days after the application date. The regular FAP due date (SOP) is 29 calendar days after the application date.

FAP benefits must be **available** by the seventh day for expedited and the 30th day for regular FAP. Available means clients **must** have a Bridge card and access to their benefits by the seventh day for expedited and the 30th day for regular FAP benefits.

INTERVIEWS

FIP, SDA, RCA, CDC and FAP

The purpose of the interview is to explain program requirements to the applicant and to gather information for determining the group's eligibility.

The interview is an official and confidential discussion. Its scope must be limited to both of the following:

- Collecting information and examining the circumstances directly related to determining the group's eligibility and benefits.
- Offering information on programs and services available through MDHHS or other agencies.

The person interviewed may be any responsible group member **or** AR. For CDC, the AR **cannot** be the child care provider, a department employee, or a recruiter. The client may have any other person present.

Do the following during the interview:

- State the client's rights and responsibilities; see BAM 105.
- Review and update the application.
- Help complete application items **not** completed when it was filed.
- Resolve any unclear or inconsistent information.
    - Note: For FAP, if the clients' expenses exceed their income, have a discussion with them and document the case.
    - Determine the client's expenses and current situation by:
        - Adding all of the client's expenses such as rent, mortgage, utilities, taxes, etc. When determining the utility amount to include in the calculation, do **not** use the heat and utility standards; use the average monthly amount the client is responsible to pay. Verification of their actual bill(s) is not required.

- Asking if they are behind in their bills. For example, ask if they have a shutoff notice, eviction, foreclosure, defaulted on a medical bill, someone else is paying their expenses, etc. If they are not current on their bills or someone else is paying their bills, a front-end eligibility (FEE) referral may not be needed based on the specialist's discussion with the client.

- If after the expenses vs. income calculation is completed and the client's situation is still questionable, open the case and refer to FEE.

- Document the entire interview. An interview guide is available in Bridges as a source for documentation (for MDHHS-1171 and MI Bridges applications). Request needed verification **not** brought to the interview.

- Advise the client of the SOP for processing.

- Make services referrals if needed.

- Confirm if the client needs a Mihealth card and/or Bridge card.

- Advise cash and/or FAP clients how and when they receive benefits.

Note: For FAP, the client or AR (interviewed on the client's behalf) must be offered a copy of their completed application. The copy must have the Social Security numbers for anyone listed and/or any mention of domestic violence, redacted.

FAP and CDC

An interview is required before denying assistance even if it is clear from the application or other sources that the group is ineligible.

Note: For CDC do not deny the application if the client has not participated in the scheduled initial interview until the 10th day after the scheduled interview, in order to provide time for the client to reschedule. If the client reschedules the interview and again fails to participate, CDC may be denied.

FAP Only

Do **not** deny the application if the client has not participated in a scheduled initial interview until the 30th day after the application

date **even** if he/she has returned all verifications; see **Scheduling Interviews** for FAP only in this item.

FIP Only

In addition to the above requirements, the following must be reviewed with **all** adult mandatory group members during the FIP interview:

- Work participation requirements. Identify any potential deferrals listed in BEM 230A.
- Direct support service opportunities, including transportation and child care required to attend the PATH orientation; see BEM 229.
- Family Self-Sufficiency Plan (FSSP) requirements listed in BEM 228.
- Penalties for non-compliance; see BEM 233A.
- FIP time limits; see BEM 234.
- Child support requirements; see BEM 255.
- Vendoring payments request; see BAM 425.
- Prohibited use of FIP to purchase lottery tickets, alcohol or tobacco. It is also prohibited for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, cruise ships or other nonessential items.

The local office may exempt a relative caretaker or unrelated caretaker ineligible grantee and dependent child member adds from the FIP interview requirements.

FIP, SDA, and RCA

An interview is **not** required before denying assistance if it is clear from the application or other sources that the group is ineligible.

MA Only

Do **not** require in-person interviews as a condition of eligibility.

Telephone Interviews

CDC and FAP Only

Conduct a telephone interview at application before approving benefits. However, conduct an in-person interview if one of the following exists:

- The client requests one.
- The specialist determines it is appropriate. For example, the information in the application is suspected to be fraudulent.
- Do not require an in-office interview if the client is experiencing a hardship which prevents an in-office interview. Instead, conduct the in-person interview at the client's home or another agreed-upon location. Hardship conditions include but are not limited to: illness, transportation difficulties, work hours, etc.
- The application is a joint SDA/RCA and FAP application; see Jointly Processed SDA/RCA and FAP applications in this item.

Note: When conducting a telephone interview, ask the caller a question only the head of household could answer (such as last four digits of his/her SSN, date of birth, etc.) to ensure the identity of the caller. The best practice is to document the case record with the answer to the question.

CDC Only

If an application is submitted in which the CDC asset question is not addressed, the client must be asked during the telephone interview if the program group has assets that exceed $1 million.

FIP Only

Note: The specialist must conduct a interview at application with **each** adult mandatory group member before approving benefits. When conducting a telephone interview, ask the caller a question only the individual being interviewed could answer (such as last four digits of his/her Social Security number, date of birth etc.) to ensure the identity of the caller. Document the case record with the answer to the question. Complete this step for **each** adult mandatory group member.

Interviews

FIP,RCA,SDA Only

The specialist must conduct an in-person interview for **each** adult mandatory group member at application before approving benefits if any of the adult mandatory group members request an in-person interview.

SDA and RCA

The specialist must conduct a telephone or in-person interview at application before approving benefits..

SDA

Do **not** deny assistance if the applicant is a resident of a juvenile justice facility whose verified expected release date is within two weeks of the date the SDA application was received. Schedule an interview with the applicant to be held within the first five days after release, if possible.

Jointly Processed SDA/RCA and FAP Applications

Conduct an interview at application before approving benefits. For FAP, do not require an in-office interview if the client is experiencing a hardship which prevents an in-office interview. Instead, conduct the FAP interview by telephone, at the client's home or another agreed-upon location. Hardship conditions include but are not limited to: illness, transportation difficulties, work hours, etc.

Home Calls

All Programs

If eligibility factors are questionable, schedule a home call in Bridges; see Helping Clients in this item.

Document the reason for the home call in the case record.

For **FAP only**, some clients who are unable to appoint an AR for the interview may request it be held at their home or other convenient place. These include:

- Groups made up entirely of members age 60 or older or mentally or physically disabled.

- Groups unable to come to the local office due to a specific problem such as illness, care of a group member, rural isolation, prolonged severe weather or work/training hours.

Note: Migrant groups may be interviewed at the work site.

Schedule interviews outside the office in advance and hold them during normal weekday working hours **unless** the client requests another time. When requested, obtain prior supervisory approval. Do **not** enter a home without permission or under false pretenses. Home searches are prohibited.

Single Interview

FIP, SDA, RCA, CDC, and FAP Only

Clients applying for multiple programs such as SDA/RCA and FAP **cannot** be required to attend separate interviews for each. For jointly processed SDA/RCA and FAP applications where the client is experiencing a hardship, the FAP interview must be conducted by telephone, at the client's home or another agreed-upon location. Hardship conditions include but are not limited to: illness, transportation difficulties, work hours, etc.

Scheduling Interviews

FIP, SDA, RCA, CDC and FAP

Schedule interviews in Bridges promptly to meet the SOP .

For **FAP only** schedule the interview as a telephone appointment **unless** specific policy directs otherwise. The interview must be held by the **20th** day after the application date to allow the client at least 10 days to provide verifications by the 30th day.

SDA Applicants Exiting Juvenile Justice Facilities

For **SDA** applications received up to two weeks prior to the applicant's expected release date from a juvenile justice facility, schedule the interview to be held within the first five working days after release, if possible, or, if not, as soon as possible.

Missed Interviews

FIP, SDA, and RCA Only

If the client misses an interview appointment, the application may be denied after the 10th day from the date the MDHHS-170, Appointment Notice, was sent.

FAP Only

If clients miss an interview appointment, Bridges sends a DHS-254, Notice of Missed Interview, advising them that it is **the clients'** responsibility to request another interview date. It sends a notice only after the **first** missed interview. If the client calls to reschedule, set the interview prior to the 30th day, if possible. If the client fails to reschedule or misses the rescheduled interview, deny the application on the 30th day. If failure to hold the interview by the 20th day **or** interview rescheduling causes the application to be pending on the 30th day; see Processing Delays in this item.

ELIGIBILITY DECISIONS

Denials

All Programs

If the group is ineligible **or** refuses to cooperate in the application process, certify the denial within the SOP to avoid receiving an overdue task in Bridges.

Bridges sends a DHS-1605, Client Notice, or the DHS-1150, Application Eligibility Notice, with the denial reason(s). Medicaid denials receive a DHS-1606, Health Care Coverage Determination Notice.

FAP Only

An interview is required before denying assistance even if it is clear from the application or other sources that the group is ineligible. For non-expedited FAP, the interview must be scheduled **to occur** by the 20th day to allow the client at least 10 days to provide verifications by the 30th day. Do not deny the application if the client has not participated in the initial interview until the 30th day after the application date even if he/she has returned all verifications.

Subsequent Processing

FAP Only

Proceed as follows when a client completes the application process **after denial** but within 60 days after the application date.

On or before the 30th day:

- Re-register the application, using the **original** application date.
- If the client is eligible, determine whether to prorate benefits according to initial benefits policy in this item.

Between the 31st and 60th days:

- Re-register the application, using the date the client **completed** the process.
- If the client is eligible, prorate benefits from the date the client complied.

Approvals

All Programs

Bridges sends the DHS-1605 detailing the approval at certification of program opening.

Bridges sends the DHS-1606 detailing Medicaid approvals. Send the following publications, as appropriate, if **not** given at application:

- MDCH-201, Your Rights and Responsibility in a Health Plan.
- MDCH-669, Medicaid Fee For Service Handbook.
- MSA Pub. 617, Medicaid Deductible Information.
- MDCH Pub. 726, Nursing Facility Eligibility.
- MDCH Pub. 769, Getting the most out of life by getting the most out of health care.

CDC Notices

Bridges sends the DHS-198, Child Development and Care Provider Notice, to each provider who has been authorized to provide care for eligible children and the DHS-198-C, Child Development and Care Client Notice, to the client. These forms notify the provider and client of the application approval and authorization of care.

Designation of Head of Household

All Programs

A member of the group must be designated as head of household for purposes of case identification and benefit issuance.

Normally, the group chooses the head of household. Designate a member **if either of the following**:

- Policy prohibits the group's choice from acting as head of household**.**
- The group fails to designate a head of household or disagrees about who it should be.

For **CDC**, see BEM 205, APPLICANT; and BAM 110, Who May Apply.

FIP Only

The person designated as head of household must meet the definition of caretaker; see BEM 210.

MAGI-Related MA Only

Designate a core relative as head of household for any case with an unmarried person under age 18 for whom support action is required per BEM 255.

FAP Only

An ineligible or disqualified person can be the head of household **if** he/she is the only adult in the group.

Note: The person is identified as a disqualified EDG member in Bridges.

Initial Benefits

FIP and SDA Only

Provided the group meets all eligibility requirements, begin assistance in the pay period in which the application becomes 30 days old.

If the application becomes 30 days old and the group has **not** met eligibility requirements, begin assistance for the first pay period when it does.

Bridges issues initial benefits as appropriate.

RCA Only

RCA begins the pay period:

- **After** the pay period that includes the application date.
- Provided the group meets all eligibility requirements in that pay period.

  Note: Do not delay approval of RCA benefits solely for employment and self-sufficiency activity requirements. Participation in self-sufficiency activities is not a condition of initial eligibility, however it is a condition of continued eligibility.

If the application becomes 30 days old and the group has **not** met eligibility requirements, Bridges begins assistance in the pay period the group meets the requirements.

FIP and SDA Only

For **member adds**, see BEM 515, CHANGES IN NEED, and BAM 110, Date of Application for Member Add.

FAP Only

Bridges prorates benefits for the month of application, beginning with the date of application, when the group is eligible for the application month.

Exception: Migrant/seasonal farmworker groups that were active in the Food Assistance Program the month **before** the date of application are eligible for a full month's benefit. This policy applies whether the entire group (or any migrant member of the group) was last active for FAP in Michigan or another state.

CDC Provider Assignment Effective Date

CDC Only

The first day that a child care provider may be assigned to a child is the latest of the following:

- The CDC application receipt date.

  - ***Exception:*** For foster care only, 21 calendar days prior to the CDC application receipt date.

- The date the child care began (listed on the DHS-4025).
- The date the provider becomes eligible for subsidy payments.
- 60 calendar days prior to the receipt of a completed DHS-4025.

Note: For payment issuance requirements and provider assignment restrictions; see BEM 706, Provider Payments.

Benefit Periods

FIP and SDA Only

The group's benefit period continues until it no longer meets the program's eligibility requirements.

MA Only

Benefit periods are discussed in various BEM items. Retro MA Applications are addressed in this item.

MA Only Except ALMB

Certify MA groups for 12 months when:

- **All** group members are senior and/or disabled, **and**

- The group's **only** source of income is SSI and/or RSDI benefits, **and**

- The group is also receiving a 24-month benefit period for FAP.

Note: The FAP Mid-Certification form may be used to perform an ex parte review for a second 12-month Medicaid period.

Exception: ALMB eligibility must be completed before the end of each calendar year. Set the ALMB redetermination date as September, October, November or December, but no more than 12 months.

FAP Only

The group is eligible for a specific benefit period (in calendar months) with a begin and end date.

Begin Date At Application

The FAP **begin date** depends on the group's eligibility **and** whether the 30-day SOP has been met; see Subsequent Processing in this item. Use the following criteria:

- When the 30-day SOP is met, **or** it is **not** met but the group is **not** at fault for the delay, the **begin date** is either of the following:
  - The application date **if** the group is eligible for the application month (**even if** proration causes zero benefits).
  - The first day of the month **after** the application month **if** that is when the group becomes eligible.
- When the 30-day SOP is **not** met and the group is at fault for the delay, the **begin date** is the date the group meets all application requirements; see FAP Fault Determination in this item.

Exception: See BEM 610 to determine the begin date for migrant/seasonal farmworkers.

Begin Date At Redetermination

The FAP **begin date** is the first day of the first month of the new benefit period.

End Date

The **end date** used at application or redetermination is always the last day of the final benefit month. Eligibility **cannot** continue without a redetermination and authorization of a new benefit period; see BAM 210, Redetermination.

Assigning a Benefit Period

Bridges assigns the **longest** benefit period possible based on the group's circumstances. Certain groups are given a specific **minimum** or **maximum** benefit period. Unless a specific period is required, benefit periods are assigned to accommodate the group's circumstances. The prorated month counts as the first calendar month of the benefit period.

Use the following guidelines and the group's circumstances to establish the group's benefit period.

Benefit Period to Coordinate with Other Programs

Apply the following policy **only** to FAP groups that do **not** have countable earned income. For FAP groups with countable earnings, see 12-Month Benefit Period in this item.

If the FAP program was opened prior to the other program and the client applied for both programs at the same time, either of the following may be done:

- Redetermine eligibility for the other program when the FAP benefits are due to expire (this may result in an 11-month redetermination for the other program).
- Redetermine FAP so the end date is extended to the last day of the other program's redetermination month, **provided** this does **not** exceed 12 months.

Exception: It may not be possible to coordinate FAP benefit periods for groups that qualify for 24-month benefit periods or groups that require a shorter benefit period.

24-Month Benefit Period

Bridges assigns a 24-month benefit period for groups in which **all** group members are senior and/or disabled **and** the group does not have any income or its **only** source of income is SSI and/or RSDI benefits.

Note: The annual mass update in RSDI and SSI benefit amounts does **not** affect this certification.

If a group reports a change in circumstances that affects its benefit period, such as a non-disabled/non-senior person joining the household, Bridges does all of the following:

- Shortens the benefit period according to policy in BAM 220.
- Schedules a redetermination.
- Sets a new (12 months or less) benefit period consistent with the group's circumstances.

Conduct a mid-certification contact with the FAP group once each year. The RD-093, Redetermination Report - Worker Listing, serves as notification that contact is due; see BAM 210.

12-Month Benefit Period

Bridges assigns a maximum 12 months for FAP groups that do **not** qualify for a 24-month benefit period or that do not require a shorter benefit period. For example:

- FIP groups with no earnings.
- Group has unearned income such as unemployment compensation benefit (UCB), child support, etc.

Note: FAP groups with countable earnings must have a 12-month benefit period. Conduct a mid-certification contact with the FAP group once each year. A notice will be sent when a contact is due on the RD-093, Redetermination Report - Worker Listing; see BAM 210.

Three-Month Benefit Period

If a group's circumstances are not stable and do not fit any other benefit period, a three-month benefit period **may** be assigned. Benefit periods for these groups should be determined on a case-by-case basis. Always assign the longest benefit period possible. Three months is the **minimum** benefit period which can be assigned.

Example: Kathy has no income but has a shelter obligation. Assign a three-month benefit period or a 12-month benefit period based on the case circumstances. If based on her case circumstances, it is determined a three-month benefit period is warranted, indicate this on the Unstable Circumstances Details Screen. Document the rationale for choosing the benefit period given.

Example: Kathy has no income and no obligation for rent and utilities because she is living with friends. After discussion with the client, it is determined a 12-month benefit period is appropriate.

Example: Kathy has no income but has a shelter obligation. She has applied for FIP. A 12-month benefit period **may** be given.

Deferred Actions

All Programs

To speed eligibility determinations, defer **completion** of required actions listed below.

FIP, SDA and MA Only

Referral to the prosecutor of spouses or parents of minor head of households living outside the home. The referral must be made within 14 days of the case opening.

MA Only

Receipt of a reply to an interstate inquiry regarding clients who moved to Michigan within 30 days before applying. Make the interstate inquiry **before** approving the application.

FAP Only

When processing expedited service applications both of the following actions are deferred:

- Verifications, other than identity.
- For FIP/SDA/RCA-related Food Assistance groups, actions required for the other program.

See BAM 117.

CDC Only

When processing applications for groups entitled to CDC expedited service, defer verifications, other than identity; see BAM 118.

Follow-Ups

All Programs

Create a manual task in Bridges or other follow-up device when either of the following occur:

- Information indicates a potential change in circumstances**.**
- An action has been deferred.

Bridges will automatically display the task for follow-up on the date that is specified.

Department Errors

All Programs

As soon as possible, document and correct benefits approved or denied in error by changing Data Collection, running Eligibility Determination Benefit Calculation (EDBC) and certifying the results.

Bridges sends the client a timely or adequate notice as appropriate for department error corrections resulting in:

- Program eligibility or ineligibility.
- Increased or decreased need.
- Higher or lower patient-pay amount.

FIP, SDA, RCA and FAP Only

See BAM 405, FIP, RCA AND SDA SUPPLEMENTAL BENEFITS, and 406, SUPPLEMENTAL FOOD ASSISTANCE BENEFITS, regarding supplemental benefits.

See BAM 705, AGENCY ERROR OVERISSUANCES, and BAM 715, CLIENT/CDC PROVIDER OVERISSUANCE, regarding recoupment.

CDC Only

See BAM 705, AGENCY ERROR OVERISSUANCES, for procedures to be followed when a department error has occurred.

MA Only

The period of erroneous coverage **cannot** be removed from or reduced in Bridges.

Service Referrals

All Programs

Clients may be in need of referrals to Adult Services, Adult Protective Services, Preventive Services For Families, or Children's Protective Services. Be alert to those needs and refer cases when indicated or required. If there is a disclosure of domestic violence, and the client is not receiving services, refer the client to the appropriate community service.

If there is reasonable cause to believe an adult or child has been abused, neglected or exploited, make a referral immediately by calling 1-855-444-3911.

For all other service programs follow local office procedures.

FIP and MA Only

Inform clients under age 21 of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. At an in-person interview, give the client MSA Pub. 491 or 498. Use local office procedures for EPSDT scheduling and/or transportation.

CASE ASSIGNMENT

All Programs

Bridges assigns cases to the next available specialist based on the specialist's Manage Office Resources profile and/or special skills such as language, long-term care etc.

Application assignment does not differentiate between case managers and non-case managers (NCM). If a cash application is assigned to an NCM, and Bridges builds a FIP or RCA Eligibility Determination Group (EDG), reassignment to a case manager must be accomplished manually.

PROCESSING DELAYS

All Programs

If an application is **not** processed by the SOP date, document the reason(s) in the case record. Document further delays at 30-day intervals.

Exceeding the SOP **cannot** be the **sole** reason for a denial.

When one program approval/denial will exceed the SOP, certify eligibility results for any others such as FAP within the SOP, if possible.

FAP Fault Determination

FAP Only

For a pended application, determine who is at fault for the delay every 30 days after the application date.

Note: This affects an approval of benefits for the months of delay, but **not** necessarily a denial; see Denials under Eligibility Decisions in this item.

FAP Group at Fault

If the 30-day SOP is **not** met **and** the group is at fault, the following applies:

- Select **yes** for the Extend SOP due to group at fault question on the Program Request Details screen for FAP.
- Bridges sends a DHS-1150-E, Food Assistance Application Notice, to inform the group that the EDG is pended and will be denied on the 60th day unless the needed actions are taken.
- Bridges prorates benefits from the date the group complies with all application requirements.

The group is at fault when you have taken all required actions but the group has **not** complied with either of the following:

- Provided all verifications by the 30th day, despite 10 days or more to provide them**.**
- Participated in the scheduled interview; see Interviews in this item.

Local Office at Fault

If all necessary actions have not been completed **and** the application will pend beyond the 30th day, the following applies:

- Send the group a DHS-5301, Pending Food Assistance Application Notice, to inform them of the pending status.
- Take prompt action to correct the cause of the delay.
- If eligible, the group's benefits begin with the application date.

The local office is at fault if the specialist fails to:

- Request necessary verifications at least 10 days before the 30th day.
- Provide requested help to complete the application process or secure verifications.
- Schedule a timely interview, resulting in less client time than policy requires to take an action; see Interviews in this item.
- Run EDBC and certify results to authorize benefits.

FAP Delays Beyond 60 Days

FAP Only

If the application pends beyond 60 days, obtain missing information, if possible, and process the application. There are three possible consequences:

- **Case information complete**. If the group is eligible **and** the local office was at fault on the 30th day, authorize benefits from the application date. If the group was at fault on the 30th day, benefits begin on the date the group completes the application process.
- **Local office at fault, case information *not* complete.** Request missing information via DHS-1150, Application Eligibility Notice, and verification checklist if appropriate. Give the group 10 days to provide verifications. Authorize benefits as for complete cases above.
- **FAP Group at fault, case information *not* complete**. This occurs **only if** verification requested between the 30th and 50th day was **not** provided, and the application is still pending. Deny the application by running EDBC and certifying the results immediately.

LEGAL BASE

FIP

MCL 400.25
45 CFR 260.10
Mich Admin Code, R 400.3107, 400.3108, 400.3110, 400.3111, 400.3155, 400.3156

RCA

45 CFR 400.50 - 400.53

RMA

45 CFR 400.93 - 400.104

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

SDA

Current Annual Appropriations Act
Mich Admin Code, R 400.3151 - 400.3180

MA

42 CFR 431, 435

The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

FAP

7 CFR 273.2